		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019091

Facility Name: NORTHWEST HOME FOR THE AGED

Address: 6300 N. CALIFORNIA (Number) CHICAGO (City) 60659 (Zip Code)

County: COOK

Telephone Number: (773) 973-1900 **Fax #** (773) 973-1904

IDPA ID Number: 36-2216170

Date of Initial License for Current Owners: 02/01/73

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MICHAEL PERL
(Title) EXECUTIVE DIRECTOR

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	164	Skilled (SNF)	164	60,024	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	164	TOTALS	164	60,024	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,659	6,761	5,517	26,937	8
9	SNF/PED					9
10	ICF	11,460	2,906		14,366	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,119	9,667	5,517	41,303	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.81%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/1/73

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 164 and days of care provided 5,517

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	341,014	58,827	4,800	404,641		404,641		404,641			1
2	Food Purchase		260,476		260,476	(59,292)	201,184		201,184			2
3	Housekeeping	281,015	38,059		319,074		319,074		319,074			3
4	Laundry	107,825	9,659		117,484		117,484		117,484			4
5	Heat and Other Utilities			165,719	165,719		165,719		165,719			5
6	Maintenance	40,779	35,902	65,594	142,275		142,275		142,275			6
7	Other (specify):*			33,869	33,869		33,869		33,869			7
8	**TOTAL General Services**	770,633	402,923	269,982	1,443,538	(59,292)	1,384,246		1,384,246			8
	B. Health Care and Programs											
9	Medical Director			12,500	12,500		12,500		12,500			9
10	Nursing and Medical Records	2,600,455	193,656	10,950	2,805,061		2,805,061		2,805,061			10
10a	Therapy	93,254		3,112	96,366		96,366		96,366			10a
11	Activities	159,669	39,276	1,568	200,513		200,513		200,513			11
12	Social Services	155,852			155,852		155,852		155,852			12
13	Nurse Aide Training											13
14	Program Transportation			5,241	5,241		5,241		5,241			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,009,230	232,932	33,371	3,275,533		3,275,533		3,275,533			16
	C. General Administration											
17	Administrative	122,667			122,667		122,667		122,667			17
18	Directors Fees											18
19	Professional Services			70,811	70,811		70,811	(100)	70,711			19
20	Dues, Fees, Subscriptions & Promotions			99,140	99,140		99,140	(76,141)	22,999			20
21	Clerical & General Office Expenses	166,094	33,126	57,541	256,761		256,761		256,761			21
22	Employee Benefits & Payroll Taxes			849,686	849,686	59,292	908,978		908,978			22
23	Inservice Training & Education			2,421	2,421		2,421		2,421			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			3,520	3,520		3,520		3,520			25
26	Insurance-Prop.Liab.Malpractice			233,840	233,840		233,840		233,840			26
27	Other (specify):*			169,084	169,084		169,084	(169,084)				27
28	**TOTAL General Administration**	288,761	33,126	1,486,043	1,807,930	59,292	1,867,222	(245,325)	1,621,897			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,068,624	668,981	1,789,396	6,527,001		6,527,001	(245,325)	6,281,676			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: NORTHWEST HOME FOR THE AGED #0019091 **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	4,800	
	REPAIRS & MAINTENANCE		0	
			0	4,800
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		76,412	
	ELECTRICITY		80,891	
	WATER		0	
	CABLE TV - LOBBY		8,416	
			0	165,719
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,231	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		44,678	
	ELEVATOR MAINTENANCE & REPAIR		13,359	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,326	
	FIRE SERVICE		0	
			0	
			0	
			0	65,594
7	**OTHER**			
	SCAVENGER		33,869	
	SECURITY SERVICE		0	33,869
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,500	12,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	3,713	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,472	
	PHARMACY CONSULTANT	XVIII B 39-2	5,340	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS/DENTAL	XVIII B __-2	425	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	10,950
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,636	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	476	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	3,112
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,568	
	ACTIVITY CONSULTANT			1,568
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number NORTHWEST HOME FOR THE AGED **#0019091** **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		5,241	5,241
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	14,941	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	55,870	
			0	70,811
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	76,141	
	EMPLOYEE WANT ADS	XIX F	9,573	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	9,492	
	LICENSES & PERMITS	XIX F	3,564	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	370	99,140
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		32,355	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		25,186	
	MESSENGER SERVICE		0	
			0	57,541

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	305,200	
	UNEMPLOYMENT COMPENSATION	XIX D	12,179	
	WORKERS COMPENSATION INSURANCI	XIX D	140,958	
	HOSPITALIZATION INSURANCE	XIX D	316,397	
	EMPLOYEE BENEFITS - OTHER	XIX D	26,935	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	48,017	
	CHICAGO HEAD TAX	XIX D	0	849,686
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,421	2,421
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		3,520	3,520
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		233,840	233,840
27	**OTHER**			
	BAD DEBTS	VI 24	169,084	
				169,084

GRAND TOTAL COLUMN 3 OTHER 1,789,396

NORTHWEST HOME FOR THE AGED
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	260,476
LESS SALES TAX	0
NET FOOD	260,476
TOTAL PATIENT CENSUS	41,303
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	123909
ADD # EMPLOYEE MEALS/DAY	100
TIME # DAYS	366
TOTAL EMPLOYEE MEALS	36600

PATIENT MEALS	123909
ADD EMPLOYEE MEALS	36600
TOTAL MEALS/YEAR	160509
NET FOOD	260476
DIVIDE TOTAL MEALS/YEAR	160509
COST PER MEAL	1.62
TIME EMPLOYEE MEALS	36600
EMPLOYEE MEAL RECLASSIFICATION	59292

Facility Name & ID Number NORTHWEST HOME FOR THE AGED #0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			189,109	189,109		189,109		189,109			30
31	Amortization of Pre-Op. & Org.			4,106	4,106		4,106		4,106			31
32	Interest			1,298	1,298		1,298		1,298			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,108	7,108		7,108		7,108			35
36	Other (specify):*											36
37	**TOTAL Ownership**			201,621	201,621		201,621		201,621			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		128,662	256,172	384,834		384,834		384,834			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			90,036	90,036		90,036		90,036			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		128,662	346,208	474,870		474,870		474,870			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,068,624	797,643	2,337,225	7,203,492		7,203,492	(245,325)	6,958,167			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(169,084)	27		24
25	Fund Raising, Advertising and Promotional	(76,141)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(100)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (245,325)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (245,325)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

NORTHWEST HOME FOR THE AGED

ID# 0019091

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	TOWING EXPENSE	(100)	19	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(100)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(100)	0	0	0	0	0	0	0	0	0	0	(100)	19
20	Fees, Subscriptions & Promotions	(76,141)	0	0	0	0	0	0	0	0	0	0	(76,141)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(169,084)	0	0	0	0	0	0	0	0	0	0	(169,084)	27
28	**TOTAL General Administration**	(245,325)	0	0	0	0	0	0	0	0	0	0	(245,325)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(245,325)	0	0	0	0	0	0	0	0	0	0	(245,325)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(245,325)	0	0	0	0	0	0	0	0	0	0	(245,325)	45

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	INSURANCE POLICIES										1,298	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 1,298	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 1,298	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999		8
	2000		9
	2001		10
	2002		11
	2003		12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NORTHWEST HOME FOR THE AGED COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0019091

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,536 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	PATIENT CARE	24,221	1993	$ 162,933	1
2					2
3	TOTALS	24,221		$ 162,933	3

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1973	1973	$ 797,821	$ 19945	40	$ 19,945	$	$ 635,682	4
5	8		1986	1986	418,000	10450	40	10,450		193,325	5
6	6		1994	1994	682,486	17052	40	17,052		179,046	6
7											7
8											8
	Improvement Type**										
9	LAND IMPROVEMENT			1973	12,360					12,360	9
10	LAND IMPROVEMENT			1981	88,292					88,292	10
11	LAND IMPROVEMENT			1982	32,553					32,553	11
12	LAND IMPROVEMENT			1983	55,207					55,207	12
13	LAND IMPROVEMENT			1984	60,325					60,325	13
14	LAND IMPROVEMENT			1985	12,481					12,481	14
15	LAND IMPROVEMENT			1986	33,262					33,262	15
16	LAND IMPROVEMENT			1986	99,906					99,906	16
17	LAND IMPROVEMENT			1987	3,507					3,507	17
18	LAND IMPROVEMENT			1988	46,957					46,957	18
19	LAND IMPROVEMENT			1989	11,021					11,021	19
20	LAND IMPROVEMENT			1989	52,943					52,943	20
21	LAND IMPROVEMENT			1993	1,500					1,500	21
22	BUILDING IMPROVEMENT			1973	314,578					314,578	22
23	BUILDING IMPROVEMENT			1974	7,564					7,564	23
24	BUILDING IMPROVEMENT			1975	24,726					24,726	24
25	BUILDING IMPROVEMENT			1976	61,018					61,018	25
26	BUILDING IMPROVEMENT			1977	16,352					16,352	26
27	BUILDING IMPROVEMENT			1978	3,161					3,161	27
28	BUILDING IMPROVEMENT			1979	77,150					77,150	28
29	BUILDING IMPROVEMENT			1980	36,176					36,176	29
30	BUILDING IMPROVEMENT			1981	24,284					24,284	30
31	BUILDING IMPROVEMENT			1982	11,976					11,976	31
32	BUILDING IMPROVEMENT			1983	51,666					51,666	32
33	BUILDING IMPROVEMENT			1984	62,215	1,570	20	1,570		62,215	33
34	BUILDING IMPROVEMENT			1985	16,770	838	20	838		16,341	34
35	BUILDING IMPROVEMENT			1986	37,684	1,884	20	1,884		34,854	35
36	BUILDING IMPROVEMENT			1987	82,905	4,145	20	4,145		72,538	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BUILDING IMPROVEMENT	1988	$ 47,481	$ 2,374	20	$ 2,374	$	$ 39,171	37
38	BUILDING IMPROVEMENT	1990	74,626		10			74,626	38
39	BUILDING IMPROVEMENT	1991	425		10			425	39
40	BUILDING IMPROVEMENT	1991	5,901	295	20	295		3,983	40
41	BUILDING IMPROVEMENT	1992	1,755	88	20	88		1,100	41
42	BUILDING IMPROVEMENT	1993	86,526	4,326	20	4,326		49,749	42
43	BUILDING IMPROVEMENT	1994	64,428	3,222	20	3,222		33,831	43
44	AIR INTAKE	1995	3,899	194	20	194		1,843	44
45	WATER MIXING VALUE	1995	1,474	74	20	74		703	45
46	LAVETORY FAUCENTS	1995	3,662	183	20	183		1,739	46
47	HOT WATER SYSTEM	1995	10,982	549	20	549		5,216	47
48	BATH TUB SLIPRESISTENT	1995	2,700	135	20	135		1,282	48
49	GENERATOR	1995	22,900	1,145	20	1,145		10,878	49
50	NEW WALL	1996	1,405	70	20	70		595	50
51	RETURN DUCK	1996	528	26	20	26		221	51
52	H20 WATER HEATER	1996	10,711	536	20	536		4,556	52
53	H20 BOOSTER	1996	14,484	724	20	724		6,154	53
54	NEW WINDOWS	1996	763	38	20	38		323	54
55	ROOF	1996	6,000	300	20	300		2,550	55
56	SEWER SYSTEM	1996	2,350	118	20	118		1,003	56
57	NEW DECK	1996	6,100	305	20	305		2,593	57
58	SERVICE SWITCH	1996	820	41	20	41		348	58
59	ELECTRICAL	1996	2,905	145	20	145		1,233	59
60	GUTTER BOX	1996	625	31	20	31		264	60
61	ELECTRICAL WORK	1996	3,300	165	20	165		1,402	61
62	ELECTRICAL SERVICE	1996	590	30	20	30		255	62
63	ELECTRONIC MAGNETIC DOOR	1996	624	31	20	31		264	63
64	FIRE DOORS	1996	10,100	505	20	505		4,292	64
65	BOILDER FLUE PIPE	1996	2,296	115	20	115		977	65
66	HORIZONTAL WATER COOLED A/C	1996	9,000	450	20	450		3,825	66
67	NEW PUMPS	1996	9,875	494	20	494		4,199	67
68	NEW VALVES	1996	2,368	118	20	118		1,003	68
69	ROOF	1997	35,350	1,767	20	1,767		13,253	69
70	TOTAL (lines 4 thru 69)		$ 3,683,799	$ 74,478		$ 74,478	$	$ 2,606,822	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,683,799	$ 74,478		$ 74,478	$	$ 2,606,822	1
2	NEW BATHROOM FLOORS	1997	3,198	160	20	160		1,200	2
3	MANHOLE REPAIR	1998	2,350	117	20	117		761	3
4	TILING	1998	23,105	1,155	20	1,155		7,508	4
5	ROOF TOP UNIT	1998	6,370	319	20	319		2,073	5
6	CUSOM CABINTRY	1999	3,300	165	20	165		908	6
7	CONCRETE RAMPS	1999	2,000	100	20	100		550	7
8	SLIDING DOOR	1999	9,046	452	20	452		2,486	8
9	TILING	1999	6,679	334	20	334		1,837	9
10	PERIMITER PLASTIC	1999	2,250	112	20	112		616	10
11	WINDOWS	1999	4,760	238	20	238		1,309	11
12	NEW MANHOLE	1999	3,180	159	20	159		875	12
13	DRAIN PIPES	1999	2,800	140	20	140		770	13
14	KICK PLATES	1999	4,070	204	20	204		1,122	14
15	COOLING EQUIPMENT	1999	8,142	407	20	407		2,238	15
16	ELECTRIC EYE	1999	3,141	157	20	157		864	16
17	WINDOWS	2000	1,076	54	20	54		243	17
18	SIGN	2000	6,150	307	20	307		1,382	18
19	FLOORING	2000	7,312	366	20	366		1,647	19
20	CUBICLE CURTAINS	2001	10,147	507	20	507		1,775	20
21	WINDOWS	2001	2,060	103	20	103		360	21
22	ELEVATOR REHAB	2001	20,485	1,024	20	1,024		3,584	22
23	DRAINS AND GREASE TRAPS	2001	3,500	175	20	175		437	23
24	CONDENSING UNITS AND WIRING	2001	9,965	498	20	498		1,171	24
25	TILING	2001	82,110	4,106	20	4,106		14,371	25
26	OVERBED LIGHTS AND SCONCES	2001	28,520	1,426	20	1,426		5,291	26
27	STEEL DOORS	2001	2,640	132	20	132		462	27
28	WALLCOVERINGS	2001	4,168	208	20	208		728	28
29	CORNICES WITH BLACKOUT LINED DRAPERY	2001	18,276	914	20	914		3,199	29
30	FLOORING	2001	31,589	1,580	20	1,580		5,530	30
31	PAINTING	2001	48,425	2,421	20	2,421		8,474	31
32	CORNICES	2001	8,833	442	20	442		1,547	32
33	CRASHBARS, WALL BORDERS & CORNERGUARDS	2001	29,120	1,456	20	1,456		5,096	33
34	TOTAL (lines 1 thru 33)		$ 4,082,566	$ 94,416		$ 94,416	$	$ 2,687,236	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,082,566	$ 94,416		$ 94,416	$	$ 2,687,236	1
2	CORNICES, CORNER GUARDS & CUBICLE TRACKS	2001	15,202	760	20	760		2,660	2
3	BUILT-IN WARDROBES	2001	54,924	2,746	20	2,746		9,611	3
4	TILING, WALLPAPER & PAINTING 4 BATHROOMS	2001	11,741	587	20	587		2,055	4
5	SCONCES	2001	1,179	59	20	59		207	5
6	CORNER GUARDS	2001	345	17	20	17		60	6
7	AMBULANCE DOOR	2001	420	21	20	21		73	7
8	WALLCOVERING	2001	2,288	115	20	115		402	8
9	CUSTOM ORDER SCREEN SPRINT	2001	9,825	491	20	491		1,718	9
10	CARPETING	2001	8,810	441	20	441		1,543	10
11	VINYL FLOORING IN ACTIVITY ROOM	2001	5,287	264	20	264		924	11
12	CROWN MOLDING & HANDRAILS	2001	7,266	363	20	363		1,271	12
13	CRASH RAILS & BED LOCATORS	2001	9,322	466	20	466		1,631	13
14	CRASH RAILS	2001	3,346	167	20	167		585	14
15	CORNER GUARDS	2001	563	28	20	28		98	15
16	CEILING	2001	13,271	664	20	664		2,341	16
17	SCONCES	2001	1,915	191	10	191		573	17
18	PAINTING	2001	5,214	521	10	521		1,563	18
19	CUBICLE CURTAINS	2001	788	79	10	79		237	19
20	CARPETING & COVE BASE	2001	10,000	1,000	10	1,000		3,000	20
21	LAND IMPROVEMENT-CONCRETE WORK	2002	4,100	410	10	410		1,025	21
22	BLINDS	2002	658	66	10	66		165	22
23	CORNICE & DRAPES	2002	4,721	472	10	472		1,180	23
24	DOORS	2002	12,752	638	20	638		1,595	24
25	CEILING TILE	2002	1,926	96	20	96		240	25
26	FIRE CODE WORK	2002	80,256	4,013	20	4,013		10,033	26
27	FLOORING	2002	4,721	236	20	236		590	27
28	WALLS	2002	8,824	441	20	441		1,103	28
29	CEILING SYSTEM	2002	8,507	425	20	425		1,063	29
30	RECESSED DOWNLIGHTS	2002	602	30	20	30		75	30
31	WIRING	2002	6,195	310	20	310		774	31
32	EXIT DOOR ALRM CONTROL PANEL	2002	1,130	57	20	57		142	32
33	PLASTERING, PAINTING	2003	1,800	90	20	90		135	33
34	TOTAL (lines 1 thru 33)		$ 4,380,464	$ 110,680		$ 110,680	$	$ 2,735,908	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,380,464	$ 110,680		$ 110,680	$	$ 2,735,908	1
2	TILING	2003	2,495	125	20	125		187	2
3	WALLCOVERING	2003	9,951	497	20	497		746	3
4	WINDOW	2003	962	48	20	48		72	4
5	PA SPEAKER SYSTEM	2003	630	31	20	31		47	5
6	CABLE WIRE & ATLET BOXES	2003	3,215	161	20	161		241	6
7	EXIT SIGN	2003	1,230	62	20	62		93	7
8	CEILING DIFFUSES	2003	2,417	121	20	121		181	8
9	BLINDS	2004	1,000	50	10	50		50	9
10	CARPET,WALLPAPER	2004	3,897	195	10	195		195	10
11	WALLCOVERING	2004	4,122	206	10	206		206	11
12	DOORS	2004	63,245	1,581	20	1,581		1,581	12
13	DOOR MAGNET HOLDERS	2004	9,985	250	20	250		250	13
14	SMOKE DETECT	2004	6,713	168	20	168		168	14
15	PUSH BUTTON LOCKS FOR DOORS	2004	1,070	27	20	27		27	15
16	ROOF REPAIR	2004	5,541	138	20	138		138	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,496,937	$ 114,340		$ 114,340	$	$ 2,740,090	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,267,009	$ 67,956	$ 67,956	$	5-10yrs	$ 1,053,144	71
72	Current Year Purchases	99,538	6,813	6,813		10yrs	6,813	72
73	Fully Depreciated Assets	388,484					388,484	73
74								74
75	TOTALS	$ 1,755,031	$ 74,769	$ 74,769	$		$ 1,448,441	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1998 CHRYSLER T & C	1997	$ 26,467	$	$	$		$ 26,467	76
77										77
78										78
79										79
80	TOTALS			$ 26,467	$	$	$		$ 26,467	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,441,368	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 189,109	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 189,109	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,214,998	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 2,311 Description: STORAGE RENTAL
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		2003 ACURA	$ 369.88	$ 4,797	17
18					18
19					19
20					20
21	TOTAL		$ 369.88	$ 4,797	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	$		$ 22,507	$		$ 22,507	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			3,479			3,479	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			176,608			176,608	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				128,662		128,662	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Rentals Other (specify): Rodiology, Lab.	39-8				53,578			53,578	13
14	TOTAL			$		$ 256,172	$ 128,662		$ 384,834	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 788,884	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,400,154		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	185,919		6
7	Other Prepaid Expenses	2,800		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,377,757	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	677,347		13
14	Buildings, at Historical Cost	1,898,307		14
15	Leasehold Improvements, at Historical Cost	2,084,217		15
16	Equipment, at Historical Cost	1,795,159		16
17	Accumulated Depreciation (book methods)	(4,222,176)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,232,854	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,610,611	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 226,078	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	224,659		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	118,110		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	INTERFUND TRANSFER	5,827,530		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,396,377	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,396,377	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,785,766)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,610,611	$	48

*(See instructions.)

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (899,898)	1
2	Restatements (describe):		2
3	ROUNDING	76	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (899,822)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(885,944)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (885,944)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,785,766)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,037,417	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,037,417	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	118,864	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 118,864	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	(305)	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ (305)	23
	D. Non-Operating Revenue		
24	Contributions	161,053	24
25	Interest and Other Investment Income***	519	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 161,572	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,317,548	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,443,538	31
32	Health Care	3,275,533	32
33	General Administration	1,807,930	33
	B. Capital Expense		
34	Ownership	201,621	34
	C. Ancillary Expense		
35	Special Cost Centers	384,834	35
36	Provider Participation Fee	90,036	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,203,492	40
41	**Income before Income Taxes (line 30 minus line 40)****	(885,944)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (885,944)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
FORM 990 HASN'T BEEN COMPLETED YET

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,845	2,182	$ 79,286	$ 36.34	1
2	Assistant Director of Nursing	1,906	2,110	68,235	32.34	2
3	Registered Nurses	29,325	32,768	895,530	27.33	3
4	Licensed Practical Nurses	9,541	10,575	241,772	22.86	4
5	Nurse Aides & Orderlies	90,517	100,887	1,130,054	11.20	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,905	6,892	93,254	13.53	8
9	Activity Director	2,076	2,335	50,381	21.58	9
10	Activity Assistants	6,877	7,931	109,288	13.78	10
11	Social Service Workers	6,814	7,638	155,852	20.40	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,788	2,049	32,326	15.78	14
15	Cook Helpers/Assistants	27,886	30,609	308,688	10.08	15
16	Dishwashers					16
17	Maintenance Workers	1,843	2,010	40,779	20.29	17
18	Housekeepers	24,240	26,562	281,015	10.58	18
19	Laundry	7,694	9,247	107,825	11.66	19
20	Administrator	2,012	2,268	122,667	54.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,144	7,356	166,094	22.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,417	5,339	71,024	13.30	31
32	Other Health Care(specify)	3,642	4,208	114,554	27.22	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	234,472	262,966	$ 4,068,624 *	$ 15.47	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 4,800	1-3	35
36	Medical Director	O	12,500	9-3	36
37	Medical Records Consultant	N	1,472	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	5,340	10-3	39
40	Physical Therapy Consultant	L	2,636	10a-3	40
41	Occupational Therapy Consultant	Y	476	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,568	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) PHYSICIAN/DENTA	S	425	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 29,217		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	98	$ 2,841	10-3	50
51	Licensed Practical Nurses	24	872	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	122	$ 3,713		53

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MICHAEL PERL	ADMIN		$ 122,667
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 122,667

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Gate Mcdonald, Gibbens	Unemployment Consult	$ 824
KBKB	Accounting	28,250
Frost,Ruttenberg & Rothblatt	Medicare	15,389
Alfred l. Levinson	Legal	650
Micchael Best & Friedrich	Legal	5,053
Firedyne Engineering	Fire Protection Consult	1,470
Panto Uluma	Architectural Consult	3,294
Kelli Mehrholz	Marketing Consult	840
Automatic Data Processing	Data Processing	14,941
Lincoln Towing		100
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 70,811

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 140,958
Unemployment Compensation Insurance		12,179
FICA Taxes		305,200
Employee Health Insurance		316,397
Employee Meals		59,292
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		26,935
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		48,017
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 908,978

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,573
Health Care Worker Background Check	370
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	76,141
TRUST/FRANCHISE/CONTRIB/ETC	0
LICENSES & PERMITS	3,564
DUES & SUBSCRIPTIONS	9,492
MGMT CO ALLOCATION	
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(76,141)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,999

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING / DECORATI	6/99	$ 7,994	3 YRS	$ 2,664	$ 1,333	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 7,994		$ 2,664	$ 1,333	$	$	$	$	$	$	$

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **34,843** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **90,036**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **59,292** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **KRUPNICK BOKOR KAGDA & BROOKS** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **AUDIT NOT COMPLETE YET**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees